UCSF
UC San Francisco Previously Published Works

Title
Organizational values in the provision of access to care for the uninsured

Permalink
https://escholarship.org/uc/item/3ns5q73k

Journal
AJOB Empirical Bioethics, 7(4)

ISSN
2329-4515

Authors
Harrison, Krista Lyn
Taylor, Holly A

Publication Date
2016-10-01

DOI
10.1080/23294515.2016.1170075

Peer reviewed

eScholarship.org Powered by the California Digital Library
University of California

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

HHS Public Access
Author manuscript
AJOB Empir Bioeth. Author manuscript; available in PMC 2017 August 02.

Published in final edited form as:
AJOB Empir Bioeth. 2016 ; 7(4): 240–250. doi:10.1080/23294515.2016.1170075.

Organizational values in the provision of access to care for the uninsured

Krista Lyn Harrison[a] and **Holly A. Taylor**[b]

[a]Division of Geriatrics, University of California, San Francisco

[b]Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, and Johns Hopkins Berman Institute of Bioethics, Johns Hopkins University

Abstract

Background—For the last 20 years, health provider organizations have made efforts to align mission, values, and everyday practices to ensure high-quality, high-value, and ethical care. However, little attention has been paid to the organizational values and practices of community-based programs that organize and facilitate access to care for uninsured populations. This study aimed to identify and describe organizational values relevant to resource allocation and policy decisions that affect the services offered to members, using the case of community access programs: county-based programs that provide access to care for the uninsured working poor.

Methods—Comparative and qualitative case study methodology was used, including document review, observations, and key informant interviews, at two geographically diverse programs.

Results—Nine values were identified as relevant to decision making: stewardship, quality care, access to care, service to others, community well-being, member independence, organizational excellence, decency, and fairness. The way these values were deployed in resource allocation decisions that affected services offered to the uninsured are illustrated in one example per site.

Conclusions—This study addresses the previous dearth in the literature regarding an empirical description of organizational values employed in decision making of community organizations. To assess the transferability of the values identified, we compared our empirical results to prior empirical and conceptual work in the United States and internationally and found substantial alignment. Future studies can examine whether the identified organizational values are reflective of those at other health care organizations.

Keywords

bioethics; health policy empirical research; qualitative research; social science

---

CONTACT: Krista Harrison, PhD, krista.harrison@ucsf.edu, Division of Geriatrics, University of California, San Francisco, 4150 Clement St., San Francisco, CA 94121, USA.

Author contributions

Dr. Harrison conceived and designed the study, collected all data, and drafted the article. Dr. Taylor provided mentorship and significant intellectual contribution to all stages, as well as substantial revision of the article.

Conflicts of interest

None.

Ethical approval

This study was approved by the institutional review board at Johns Hopkins Bloomberg School of Public Health.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Values describe the core of what we, as individuals or communities, hold to be intrinsically important and desirable. These values influence our choices and preferences for certain outcomes. Similarly, organizational values describe what is important to the function and success of an organization. Goals, often formulated in a mission statement or code of ethics, further state or clarify those values (Mills and Spencer 2005). The extent of alignment between organizational values and daily decisions of staff can indicate whether the organization promotes a healthy ethical culture (Nelson, Taylor, and Walsh 2014).

Attention has been paid to organizational ethics and culture in hospitals since a 1995 mandate that hospitals conduct their business practices ethically (Joint Commission for Accreditation of Health Care Organizations 1995). As a result, professional groups like the American Medical Association developed guidelines for organizational ethics and ethical decision making in systems that provide health care to individual patients (like hospitals) (Ozar et al. 2000). More recently, an international research and policy network was created to research and outline the impact of social values on health care prioritization (Docherty, Cao, and Wang 2012; Kieslich 2012; Ahn et al. 2012; Keren and Littlejohns 2012; Littlejohns et al. 2012; Biron, Rumbold, and Faden 2012; Tantivess et al. 2012; Littlejohns, Sharma, and Jeong 2012). However, this work has not been extended to empirically assess the organizational values or ethics culture of community-based programs that organize access to care for vulnerable populations such as the low-income uninsured.

The health care safety net consists of organizations mission-bound or legally required to provide care for uninsured individuals, and as such these are typically underfunded and overburdened with patients in need (Lewin and Institute of Medicine 2000; Villegas 2009; Lewin and Baxter 2007). Prior to the Affordable Care Act (ACA), community access programs (CAPs) were designed by resourceful policymakers to fill gaps between safety net providers and public insurance coverage (Blewett, Ziegenfuss, and Davern 2008; Minyard et al. 2007). These locally organized and financed programs gave uninsured adults access to a structured set of health care benefits at a low cost (Minyard et al. 2007; Blewett, Ziegenfuss, and Davern 2008). According to one definition, CAPs included an enrollment mechanism (with or without a membership or monthly fee), a set of income eligibility requirements, a defined set of benefits, a limited local provider network, a set of contracts between the CAP and providers, and a local organizing entity that administered information about enrollees and managed care over time (Blewett, Ziegenfuss, and Davern 2008). As CAPs represented an organized body of people with a collective goal, we refer to them as "organizations" even though they did not necessarily have independent articles of incorporation; indeed, some CAPs were administered by a subset of staff from a larger organization, such as a county health department. Though these programs resembled formal health plans, they were not designed as insurance products and accordingly were not subject to state regulatory oversight for insurance. CAP funding was generally limited; as a result, tough trade-offs were made between breadth and depth of coverage. Some CAPs chose to provide benefit packages comparable to commercial coverage, while others explicitly limited services to basic primary, preventive care and some specialty services in order to maximize the number of enrollees served (Silow-Carroll, Alteras, and Sacks 2004).

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

The purpose of this study was to identify and describe organizational values as a first step toward understanding how those values are operationalized in the resource allocation and policy decisions of health care organizations that affect services offered to the population served. We chose community access programs (CAPs) as a laboratory to address this aim because CAPs shared characteristics with health provider organizations, public health organizations, and insurance companies. We conducted a rigorous in-depth qualitative case study of two CAPs with the goals of identifying core organizational values common to both sites and generating hypotheses to be tested in other types of health care organizations. Our study provides empirical evidence of the values used in practice by CAPs in the design and implementation of their programs, as well as an example of methodology that can be used to explore and document organizational values in other types of health care organizations programs. Our findings can be used as a basis for future studies to examine how values in other types of community-based health care organizations may be similar or different.

Methods

Study approach

A case study is an empirical inquiry that uses multiple sources of data to rigorously investigate a particular issue or set of decisions within the real-world bounded system, where the boundaries between issued studied and context are blurry (Yin 2008). In this case, the CAPs are the bounded system or “case” whose context—including CAP structure, funding streams, and political situation of county and state—is crucial to the issue of study: what organizational values are relevant to a community health organization’s resource allocation decisions.

Study sample

The study population was identified through published reports of community-based programs that broker access to care for the uninsured (Taylor, Cunningham, and McKenzie 2006; Taylor et al. 2006; Scotten and Absher 2006; Blewett, Ziegenfuss, and Davern 2008; Nakashian 2007) and identification of newly founded CAPs. Of the 50 CAPs identified and categorized into one of four organizational models defined by Blewett and colleagues, 32 were excluded that served primarily employed individuals or that were a nation-wide model of care (Blewett, Ziegenfuss, and Davern 2008). Sites were also excluded that did not have an up-to-date website, published evaluation, or five or more staff to interview. Of the eight eligible sites contacted and willing to participate, two were purposively selected for diversity of organizational model based on the Blewett typology, maturity as judged by founding date, and geographic region (Creswell 2006; Miles and Huberman 1994).

Description of participating sites

Table 1 summarizes similarities and differences in the context and characteristics of participating sites. Contexts of sites 1 and 2 were most similar with regard to county population density, cost of living, and prevalence of foreign-born persons or languages other than English spoken at home, and population diversity was similar in terms of white versus nonwhite. The county served by Site 1 had higher percentages of Asians, while the county served by Site 2 had a larger Hispanic/Latino population. Median household income was

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

much higher in the county served by Site 1, while the percent of the population living below the poverty level was much higher in the county served by Site 2.

Site 1 existed than less than 5 years in the Mid-Atlantic and was a local provider model of CAP: administered by a local health system, facilitated within a single provider network, and funded through a mix of patient contributions, county taxes, and grants. This CAP was founded to provide access to care for the low-income uninsured in a county with a high median household income, with enrollment limits set at 300% of federal poverty level. A nonprofit corporation was founded to run the CAP. Oversight was provided by a board of trustees with representatives from the county government, community members, clinician researchers, partner provider organizations, clinical providers serving enrollees, and CAP members. The CAP paid a monthly fee to a local federally qualified health center to serve as a medical home for members. Access to hospital care was provided pro bono; specialist services were available on a case-by-case basis, dependent on provider willingness to provide pro bono or discounted care. Causes for disenrollment included nonparticipation in health coaching or nonpayment of monthly premiums ranging from $50 to $130 per month based on a sliding scale.

Site 2 existed for more than 20 years in the Southeast as a county-based indigent care model: administered by a local health department, care offered through a limited provider network, and funded by local tax revenues. This CAP was founded in 1991 based on a goal to address a state mandate and provide sustainably funded health care for medically indigent residents at or under 100% of federal poverty level. County health and social service division employees ran the CAP according to the overarching policies approved by a board of county commissioners. An advisory board made policy recommendations to the board of county commissioners and consisted of representatives from the local university, county medical association, health care business, general business community, consumer nonprofit organization, school board, health insurance industry, mental health care provider, nonphysician community health care provider, network provider hospital, and two CAP enrollees. CAP members were assigned to one of four health care networks (consisting of primary care physicians, specialists, and hospitals) that were responsible for acting as medical homes, coordinating care, and providing referrals to hospital and specialty care. In 2010, the CAP added a self-sufficiency model that limited members to 2 years of eligibility; disenrollment could be effected earlier if members did not show progress toward finding employment. Site 2 served 20 times as many people as Site 1 with a budget 76 times as large.

Eligible participants

Within the two participating sites, individuals professionally involved with designing, funding, and/or administering the CAP were eligible for interviews. Individuals were targeted for recruitment based on their proximal involvement in CAP design, daily policy implementation, or major changes to services offered: CAP managers and staff, CAP leaders or former leaders, or members of advisory boards. Except where CAP enrollees, community members, and clinician partners served as members of the board or were recommended for recruitment by other participants, these perspectives were not explicitly recruited to this

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

study as likely being too distal from involvement in resource allocation decisions. Criterion and chain-referral sampling strategies were used to identify potential participants (Creswell 2006). Potential participants were recruited by a phone call or direct e-mail from the researcher or by an e-mail forwarded by a CAP key informant. Every individual recommended for an interview by a participant was recruited for participation.

Human subjects

The Johns Hopkins Bloomberg School of Public Health Institutional Review Board reviewed the project and determined that it was not human subjects research because participants were responding on behalf of the organization rather than as individuals.

Data collection

Three qualitative data collection methodologies were used: gathering documents and archival materials, making direct observations, and conducting semistructured in-depth interviews (Table 2) (Marshall and Rossman 2006; Creswell 2006). Internal CAP documents and observations of staff or board meetings were used to identify organizational values and example resource allocation decisions as they occurred naturally, as well as to identify potential participants and refine the interview guide. These data were triangulated with data from semistructured in-depth interviews with key informants, conducted to explore the following domains: (1) participant's role with the CAP and the history of the CAP, (2) organizational values, (3) example resource allocation or policy decisions that occurred at the CAP, and (4) the relationship between the organizational values and resource allocation policy decisions. Participants were invited to participate in two interviews.

The structured elements of the interviews used two different systematic interview methods to define the domain of organizational values: a free listing exercise in the first interview and a ranking exercise in the second interview (Weller and Romney 1988). All first interviews were completed before second interviews were conducted. The listing exercise systematically elicited items within the cultural domain of the CAP organization's values (Weller and Romney 1988). Participants were asked to list the values, goals, and commitments of the organization and its stakeholder groups, including board members, population served, county health department, partner organizations, funders, and politicians. Words or phrases mentioned more than once (either by one participant or by multiple participants) were written on an index card for the ranking exercise in Interview 2; index cards from all site-specific participants of Interview 1 were combined for use in Interview 2. The ranking exercise built on the listing exercise to obtain the participant's perspective on the relative importance of domain items (organizational values) with regard to a specific dimension (CAP decisions) (Marshall and Rossman 2006). Participants were asked to review the index cards and then select 5–12 cards with the words or phrases that they believed were most important to the organization's resource allocation decisions that affected services offered to the uninsured. Participants were asked to rank order the selected cards by the degree to which those factors affected CAP resource allocation and policy decisions in the CAP. Participants were also asked to discuss how the relative importance of values in such decisions has changed over time.

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Data management and analysis

Audio recordings of observations and interviews were transcribed by a professional transcription service. Complete transcripts were reviewed for accuracy and completeness and identifying information was removed or abbreviated. Data citations in this article use the following key: *s1* for Site 1, *s2* for Site 2, *d* for document, *o* for observation, or *p* for interview participant; a number following *d, o*, or *p* indicates the specific document, observation, or interview.

Content analysis techniques included organization and immersion, as well as thematic coding, examining patterns, writing memos, diagramming, and interpreting data (Miles and Huberman 1994; Marshall and Rossman 2006). Documents and transcribed observations and interviews were converted to electronic format, then uploaded to a qualitative data analysis software program: QSR's NVivo9 (QSR International Pty Ltd 2010). A codebook was developed in an iterative fashion, with an initial set of descriptive codes based on interview question domains and themes from data collection: CAP context, characteristics of the CAP, target population need, member experience, organizational values, example resource allocation decisions, economic factors, political factors, and stakeholders. Codes were given a definition, as well as directions and examples of when it would or would not be appropriate to apply the codes. Organizational values were defined as statements or allusions to principles of or judgments of what is important according to the organization or its stakeholders, including goals, motivations, and commitments. Subcodes within each category were developed through a process of applying primary codes and conducting subanalyses, as well as by writing memos identifying clusters of data as instances of a general concept (Miles and Huberman 1994). A second coder applied the codebook to a small sample of data; coding process and outcomes were discussed and used to refine the codebook. One researcher (KLH) used the finalized codebook to apply codes systematically to all data in NVivo9. Analytic memos were drafted for each site on site characteristics and organizational values (Yin 2008; Miles and Huberman 1994). An additional cross-site comparative memo was written comparing CAP structure and motivations to deepen understandings of concepts discovered in the phenomenon examined (Miles and Huberman 1994).

Reliability and validity

Member checking activities occurred through the review and ranking of organizational values in the second interview with participants, as described earlier (Creswell 2006). During this activity participants discussed whether or not the values on the cards were ones that they believed the CAP espoused. Multiple perspectives and methods were used to triangulate and capture the complexity of the case, setting, and processes (Creswell 2006; Maxwell 2004); validation occurred through the convergence of these perspectives on relevant themes.

Results

Results are based on data collected between September 1 and November 19, 2011. Site 1 data included 6 observations (3 board meetings, 3 manager meetings); 15 interviews with 9

Author Manuscript

people including 5 staff members, 2 board members, and 2 founders; and 81 documents selected from 868 provided. Site 2 data included 4 observations (1 board meeting, 3 manager meetings); 26 interviews with 19 people including 6 staff members, 6 board members, and 7 other stakeholders; and 87 documents selected from 190 provided (Table 3). The average interview lasted 45–60 minutes. We first present nine identified domains of organizational values, followed by one example resource allocation decision from each site to illustrate how the organizational values were operationalized.

Organizational Values

Both sites had written statements of the mission and goals of the organization, as well as records of changes in the mission and goals over time. The mission statements were a source of some, but not all, of the organizational value domains identified. Other value statements appeared across all data types but with greatest frequency in the in-depth interview data. The nine domains of organizational values common to both sites are presented in order of the frequency of their appearance in the data and named using the emic language of the participants.

Stewardship—This organizational value concerned efforts to achieve sustainable funding, stay solvent or financially viable as an organization, and invest resources thoughtfully, including limit setting: “We were also the stewards, because [the CAP] is run off of the tax dollars, it’s run off the citizen’s money … [W]e need to ensure that it’s being used appropriately, and it’s being used for what its primary intent is” (s2 p3.1). Site 1 stakeholders also discussed the importance of being innovative in order to maintain staff interest and attract funding.

Quality care—The organizational value of quality care consisted of statements of the attributes of the care to which the CAP wanted to provide access. Common adjectives include high quality, preventive, primary comprehensive, coordinated, medical-home based, and culturally appropriate.

Access to care—The value of access was common to CAP mission statements over time and across sites: Stakeholders wanted to ensure or facilitate access to health care for members. At Site 1, the value of access was closely related to a belief in a universal right to care and desire to ensure affordability; these subthemes were not present at Site 2. Site 2 stakeholders were focused on maximizing access to services and providing a temporary bridge to services.

Service to others—The value of service to others was formulated either generally, as a goal to help specific groups of people, or as a desire to help people achieve a specific end: “It’s about the people we’re trying to help to … take care of themselves better … [to] increase their income, be contributing members of the community” (s2 p2.2). In addition, subthemes within this domain included providing a safety net for uninsured residents and advocating for members, such as “to advocate for public policies that promote health and wellness” (s1 o5).

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Community well-being—This value comprised a belief that providing people access to high quality and comprehensive care would benefit not only the individual but also the community at large: "We're really looking at the health of the entire community, in making sure that people, all people, have access to health care" (s1 p1.2). Stakeholders saw their CAPs as local solutions to national problems like the growth of health care costs, as well as serving as potential models for providing access to care for the uninsured.

Member independence—This value had two major subdomains: personal responsibility (which appeared at both sites, but primarily at Site 1) and self-sufficiency (which appeared only at Site 2). At Site 1, stakeholders were "encouraging each member's accountability for their own health and well-being through health coaching" (s1 p1.2). At Site 2, the theme of expecting members to take personal responsibility for their health also appeared. It was most commonly expressed as helping members to no longer need help from government programs to access health care or meet other needs, for example, by obtaining employment.

Organizational excellence—CAP staff valued running their organization in particular ways, for example, acting in accordance with values, being transparent, being accountable, and engaging stakeholders. Site 1 stakeholders were more likely to refer to transparency and acting in accordance with values"[The CAP] is a healthy workplace and strives for organizational excellence, acting in a way that is aligned with our values" (s1 d01). Participants at Site 2 talked more frequently about the importance of engaging varied stakeholders and being accountable to those stakeholders in terms of keeping promises to achieve goals and using funds as promised.

Decency—The organizational value of decency comprised a belief in the type of relationship that should exist between the organization and members. Stakeholders believed that their members should be treated decently, with compassion, respect, and dignity, and that members should be empowered.

Fairness—The organizational value of fairness encompassed a goal to treat individual members or providers the same way as other members or providers. For example, staff wanted to ensure that all members had equivalent access to services and opportunities to meet the requirements of the CAP: "It is important to [the CAP] that all of our employees observe high ethical standards and treat both our customers and fellow employees fairly" (s1 d79). Similarly, CAPs wanted to ensure that the provision of care for the indigent was spread evenly across their provider networks.

Description of Case Resource Allocation Decisions to Illustrate How Values Were Deployed

The following two example decisions from each site show how organizational values influenced resource allocation decisions. The first decision illustrates how Site 1 implemented health coaching as a requirement for all participants as guided by the organizational values of member independence and stewardship (in terms of attracting funds through innovation and reducing health care costs through behavior modification). Later, the staff at Site 1 decided the health coaching program was in conflict with the values of access

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

to care, quality care, and fairness, and revised the policy to better align with organizational values.

The second decision illustrates the development of a policy at Site 2 requiring that all participants actively search for employment or other sources of health care such as disability benefits. The policy was justified as a way to promote members taking personal responsibility for their health and self-sufficiency (member independence) and to ensure the solvency of the CAP (stewardship). Once financial pressures on the program abated, the policy was revised to suspend involuntary disenrollment of members in order to better align with the values of service to others and ensuring access to care.

Health coaching requirement for access to care (Site 1)

When the CAP was designed, founders included a requirement that all members engage in health coaching based on the organizational value of member independence; nonparticipation was grounds for disenrollment (s1 p7.1). Health coaching consisted of pairing members with a professional health coach who used motivational interviewing techniques to elicit members' health goals and develop a plan of action steps to reach the goals (s1 d34, d02). Coaches called members monthly to check in and met with them in person every 3 months to assess progress and revise the plan as appropriate. Members were given many opportunities to participate and appeal decisions before finally being disenrolled for nonadherence (s1 p1.2, p2.1, p3.1, p4.1); only 12 members were disenrolled in 2 years (s1 p4.1, p5.1), less than 2% of members. The mandatory coaching program was justified as being innovative (s1 p8.1), something that might attract funding but simultaneously encourage members' personal responsibility for health (s1 p9.1). The organizational values of member independence and stewardship were the primary motivators for program initiation.

A few years into the program, program administrators identified multiple problems with the coaching program as designed. The CAP lacked funds to hire sufficient coaches to keep caseloads manageable and the program running as it was originally intended (s1 p3.1, p8.1). CAP staff disliked the requirement to disenroll noncompliant members because it conflicted with the value of access to care: "Because we know they don't have anywhere else to go for health care. So we don't want to disenroll them from the plan" (s1 p3.1). Staff time and energy were used inefficiently in complying with a cumbersome disenrollment process (s1 p3.1), which conflicted with the organizational value of stewardship. CAP staff experienced difficulty in providing culturally appropriate and translated coaching services to the 10% of members with limited English proficiency or who spoke one of more than twenty different primary languages (s1 p2.3 p3.1, p3.2, d02). As one stakeholder said, "It's difficult to kind of make sure that we're serving that population … in a culturally competent way to the extent possible and try to make sure that we're being fair" (s1 p3.1). Previous efforts to accommodate limited English proficiency member needs were either insufficient or prohibitively resource-intensive (s1 p3.1, p8.1, d16, d63). The result was a conflict with the organizational values of access to care, quality care, and fairness. All these problems were sufficient to prompt a reexamination of whether the program should be mandatory.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

After stepping back and considering the goals of the coaching program, CAP staff decided to concentrate the limited time and staff available to provide a higher quality service to members who wanted to engage in coaching (s1 p3.1, p6.1). CAP staff drafted a new coaching policy that included a new opt-out option, as well as criteria to graduate from the coaching program (s1 p3.2, p3.3, s1 o2). Instead of having a mandatory policy, they decided instead to use a financial incentive or disincentive to promote participation. Incorporating on feedback from external experts, CAP staff recommended that the board uniformly raise monthly premiums and give health coaching participants and graduates a monthly $10 discount for having been engaged (s2 o2). Staff thought $10 monthly would be sufficient to incentivize "without making it completely prohibitive for people to opt out" (s2 p3.2).

Implementation of a self-sufficiency requirement for access to care (Site 2)

In 2009, CAP staff presented an actuarial report to the board of county commissioners—the group responsible for setting CAP policy for resource allocation—indicating that the financial viability of the CAP was threatened by the recession: The sales tax-based funding had decreased while demand for services had increased (s2 d53, s2 p1.1). In response, the board of county commissioners convened a special committee and charged it with identifying short-term and long-term actions to reduce the risk of financial problems (s2 d04, d53). As one stakeholder described the dilemma, it was a question of:

> So do you reduce enrollment, or do you cut the benefits? It's a classic good health policy management kind of question. And, of course, there's no good answer to that, because the plan was put in place for a very particular reason. We didn't want to back away from that sort of commitment that we felt had been made, the sort of trust between the community and the plan. And there were a lot of emotional discussions about what is this plan really for? (s2 p14.1)

Ultimately, the committee recommended reducing enrollment or the number of people eligible for the CAP in the short-term (s2 d51). Essentially, stakeholders were faced with a tension between the organizational values of stewardship and access to care.

Rather than implementing "an artificial first come-first served cap" (s2 d53), stakeholders proposed making the CAP align with other programs offered by the county at the time by requiring enrollees to be looking for work as a method to promote members moving out of poverty (s2 p12.1, d53). The resulting policy was animated by the organizational value of member independence while implementing a trade-off: a decrease in access to care in order to increase stewardship. The "Self-Sufficiency Model" implemented in 2010 required that applicants to the CAP identify why they were not self-sufficient: either because they were "employed but not making enough income; unemployed due to a job loss; or unable to work due to the health barrier" (s2 d04). Based on the answer, members were then required to participate in certain activities to work toward self-sufficiency, such as working 20 hours a week, attending an orientation session for an employment program, or completing an application for veterans' or Social Security disability benefits (s2 d04). Case managers evaluated progress toward self-sufficiency every 6 months using "a Results Oriented Management and Accountability (ROMA) self-sufficiency scale" (s2 d53, p12.1). Under the Self-Sufficiency Model, members were limited to four 6-month periods of eligibility, a total

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

of 24 months; members had to prove progress toward self-sufficiency in order to be allowed to enroll in the next 6-month period of eligibility (s2 p10.1, p18.1, d10, d53).

Some board members were concerned about the policy because "you're dealing with people who are facing so many other obstacles as well and they don't necessarily feel empowered and while you might have said they needed to be at this interview and take care of this, they might have been trying to figure out where they were sleeping with their kids that night" (s2 p2.1). To address conflict with the organizational value of service to others, stakeholders included exceptions to the 24-month limit for members with extreme hardship or continuity of care concerns (s2 d53) such as treatment for chronic illness, surgery, or chemotherapy (s2 p10.1), in accordance with the value of decency.

In late 2011 when CAP members were approaching the first 24-month termination date, stakeholders remained concerned about the trade-off between services to others, access to care, and stewardship. The advisory board asked for an update on the Self-Sufficiency Model regarding the status of the trust fund, demographics of the members eligible for termination, and employment climate in the county (s2 p12.1). CAP staff prepared a report indicating that 2,700 members were eligible for termination, of whom "75 percent of the people are between 45 and 64, have less than a 12th-grade education … are minority, and … a household of one," that the unemployment rate had changed from 11.2 to 10.7%, and the trust fund was $1 million higher than when the SSM was implemented (s2 p12.1). Further, CAP members were hard to employ (s2 p18.1) and were competing with college-educated people for jobs and help from community workforce program (s2 p2.1). In other words, the threat to stewardship was diminished while the population's need for access to care remained high. Based on this data the advisory board discussed suspending the 2-year limit (s1 p10.1, p18.1). As one stakeholder said, "Do we really want to kick them off, because if you kick them off, what you've done is basically forced them into a situation where we were before we even instituted the health care program, which is fend for themselves, go to the emergency room when you're sick, because the county can't provide you the health care you want" (s2 p12.1). Enacting the termination clause as previously planned would have caused a conflict with the value of service to others. In the end, the advisory board voted unanimously to recommend that the board of county commissioners suspend terminating any CAP members at the end of the 24-month period, contingent on updating the board on economic conditions every 6 months (s2 p12.1, p14.1, p2.1).

Discussion

Experts in ethical health policy comment, "Among the hardest of societies' challenges in determining health policies is to identify the values and goals that frame them" (Danis, Clancy, and Churchill 2005, xxi). This study discerned and described the organizational values at two geographically and organizationally distinct CAPs. CAP stakeholders used many different ways to talk about the same concepts; one of the benefits of this study is that it provides a common vocabulary for discussing organizational values.

Participating CAP sites were similar in the density and diversity of the population served, though Site 2 served 20 times more participants than Site 1. Differences in eligibility criteria

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

reflected the needs of the population served. In a community with high median household income and low proportion in poverty, Site 1 enrolled members up to 300% of the federal poverty level 2. By contrast, Site 2 set eligibility limits at roughly 100% of the federal poverty level in a community where median household income was half as much and the percent of the population below poverty was level three times higher.

Despite the differences between the CAPs, a common set of nine organizational values was discerned. CAP stakeholders most frequently referred to factors that were part of the overarching domains of stewardship, then access to care and quality care. The least commonly referenced values were the domains of decency and fairness. Both sites tried to provide access to quality health services within the limited resources available. This set of common organizational values reflects the similar founding mission of the two participating CAPs: to effectively fund and provide access to care for the uninsured and indigent. At Site 1 this was based on a belief in a universal right to care, while at Site 2, it was based on a desire to control costs and manage care delivered under a state mandate to provide indigent residents with access to care. These founding motivations and missions affected the articulation of values at each site. We would hypothesize that health care organizations with similar missions would have the organizational values most similar to those of the participating CAPs.

The sites differed most in the domain of member independence, which at Site 1 was tied closely to the subgoal of personal responsibility, versus the subgoal of self-sufficiency at Site 2. Though not discussed explicitly by stakeholders at either site, this value reflects the underlying theme of personal responsibility for health care that arose in partisan conflicts around health reform (Wynia 2009). Both CAPs were—to varying degrees—dependent on county funds and therefore on county political support. Health care organizations less dependent on public funds and political support might find this value less prominent or important.

As stakeholders provided examples of how organizational values were apparent in resource allocation or policy decisions, values differed in their relative importance. As illustrated in two example decisions, both sites implemented policies that aligned with the values of stewardship and member independence. Site 1 revised its policy because it conflicted with the values of access to care, quality care, and fairness, while Site 2 revised its policy (after the financial threat abated) because it conflicted with the values of service to others and access to care.

CAPs and the Affordable Care Act shared a similar motivating concern: lack of access to care for the uninsured. This study reflects the organizational values of CAPs in the pre-ACA environment. With the implementation of the ACA's insurance mandate, CAPs could no longer serve their communities by providing an insurance-like product to facilitate access to care. Individuals served by CAPs typically became eligible for either Medicaid expansions or subsidies for purchase, depending on the state of residence. CAPs found new ways to serve this population, transitioning to insurance products or navigation programs.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

To assess the transferability of the values identified as relevant to CAP resource allocation decisions, we compared our empirical results to prior conceptual work. This conceptual work represents efforts to identify values that should influence decision making in all types of health care organizations, including priority setting and resource allocation decisions. We found substantial resemblance (with a few exceptions) between our empirical findings and prior conceptual work.

Graber and Kilpatrick (2008) reviewed the theoretical literature on organizational values and claim that health care organizations in the United States are influenced by the following American values: selfless service, caring, compassion, universal access to care, and individualism. These conceptually identified values parallel the empirically observed CAP organizational values of service to others, decency, access to care, and self-sufficiency, respectively. The value of individualism as described in the literature reflects a preference to serve community members who work hard and are successful and deserving, rather than all members of the community, which resonates with the subtheme of self-sufficiency identified at Site 2, where members had to prove they were trying to find employment to be eligible for services.

Winkler and Gruen (2005) propose 13 values that should guide value-laden decision making in health care organizations: competence, compassion, trust, shared decision making, fairness, empowerment, participation, common good, community benefit, quality, equity, efficiency, and sustainability. In comparison with the organizational values identified by CAP informants, Winkler and Gruen define these values more granularly than we did; many of the values they identify were subthemes identified within the described CAP organizational values. For example, decency encompasses the values of empowerment, compassion, and trust. Organizational excellence includes competence and participation. Stewardship includes efficiency and sustainability. Winkler and Gruen group these values into four action-guiding principles: provide care with compassion, treat employees with respect, act in a public spirit, and spend resources reasonably. Interestingly, the value of shared decision making did not appear in the empirically identified CAP values; the closest proxy is the value of member independence as expressed at Site 1, where health coaching was implemented to empower participants to take responsibility for their own health.

We also compared our empirical findings to a collection of studies that describe the involvement of social values in health care priority setting in different countries (Docherty, Cao, and Wang 2012; Kieslich 2012; Ahn et al. 2012; Keren and Littlejohns 2012; Littlejohns et al. 2012; Biron, Rumbold, and Faden 2012; Tantivess et al. 2012; Littlejohns, Sharma, and Jeong 2012). These studies use an analysis template generated by Clark and Weale (2012) that describes eight social values likely to be present in health care resource allocation decisions. The social values of clinical effectiveness and cost effectiveness described by Clark and Weale—related to assuring quality of benefits and maximizing the amount of health gained within budget limitations—are encompassed by the CAP values of *care* quality and stewardship. Justice/equity and fairness are similar in that they require that like cases be treated alike. With regard to the parallels between the values of member independence and autonomy, Clark and Weale argue that "the notion of autonomy goes hand in hand with that of responsibility: if one is to be self-directing and make important choices,

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

those choices will be one's own and thus also one's own responsibility" (Clark and Weale 2012, 310). CAP staff at both sites valued member independence and worked to empower and encourage members to take responsibility for their health and self-sufficiency, although they did not use the language of autonomy to describe values or activities. Clark and Weale also identify three values for the process of health care priority setting: transparency, accountability, and participation (engaging stakeholders); all three were subdomains within the CAP organizational value of organizational excellence. The only value mentioned by Clark and Weale not clearly voiced by CAP stakeholders was solidarity. They describe solidarity as having two potential aspects: either prioritizing the least well off, or sharing the financial costs of ill health and health care. Solidarity tends to be a value that appears in the European literature, whereas individualism appears in the American literature. Though CAP stakeholders do not discuss the value of solidarity, CAPs were created based on a desire to help the least well off and use public money (at least in part) to lessen the burden of the cost of health care for this population; the value of solidarity is part of their raison d'être.

From the comparison between the empirical findings of this two-site county-level study and the literature on values relevant to the national and international context of health care allocation, it is apparent parallels can be drawn. All nine of the empirically described CAP organizational values concord with one or more of the other sets of described health care values. Two values did not appear empirically in CAPs: shared decision making and solidarity; additional research would be needed to determine why these values were not apparent in or relevant to resource allocation policy decisions by CAP stakeholders. Notably, no one set of values described all nine CAP organizational values, suggesting normative advice for CAP resource allocation decisions may not be available from a single source.

Limitations

Limitations of this study include the small sample size, the potential for social desirability or recall bias, and the exclusion of provider, member, or community perspectives beyond those represented among board members. The analysis was bounded by the focus on organizational values relevant to resource allocation and did not examine the differences in perceptions of organizational values by participant type. Given the exploratory nature of this research, two cases were chosen in order to allow a deep understanding of the CAP organizational values and decision-making processes, as well as the ability to compare experiences across CAPs. The findings generated from these programs may have limited application to other CAPs; however, they can be used to inform future research that assesses the transferability of the results to other health care organizations. It is possible that informants remembered past goals, values, or events incorrectly or provided responses that were more positive than they felt or experienced, despite assurances of confidentiality. However, the frank discussions of challenges and barriers experienced in the CAPs suggest that the respondents felt comfortable, while use of multiple data sources including archival materials allowed for triangulation of data.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Conclusion

Our study provides empirical evidence of the organizational values used in practice by CAPs in the design and implementation of their programs to provide access to care for the uninsured. Future studies can examine whether these organizational values differ when explored from provider, member, or community perspectives, when explored through the lens of non-resource allocation policy decisions, or when explored between other types of community-based health care organizations.

In addition, the findings from this study can be used to examine the influence of organizational values and other factors on resource allocation and policy decisions at health care organizations. Though the ethics literature has addressed the values and principles that ought to influence health care systems, particularly in an effort to provide access to vulnerable populations, relatively little work has been done to discern and describe the values that are actually perceived and motivating in health care organizations. Many health care organizations have a mission and set of values but measure program effectiveness by achievement of health care outcomes. Achievement of organizational values may provide an additional set of standards against which to evaluate program efficiency or success.

CAPs and other health care organizations that explicitly identify and discuss their values and relative priority may experience less disruption and more efficiency when making tradeoffs in light of funding shortages or influxes. Resource allocation problems are encountered throughout all health care organizations, internationally and domestically. Although the language around values and ethics can be abstract, this study provides an accessible vocabulary that any organization might borrow to hold discussions and clarify what organizations intend in their own statements of mission and values, using examples of how those values are operationalized in resource allocation decisions.

Acknowledgments

The authors thank the study participants and are grateful for the hard work of people who run community access programs and other safety net programs to provide people with access to health care. We also thank Drs. Anne Riley, Shannon Frattaroli, Maria Merritt, Ruth Faden, David Holt-grave, Bradley Herring, Carlton Haywood, Jr., and Jessica Holzer for their review of and comments on this work.

An early version of this work was presented as a poster at the American Public Health Association Annual Meeting, Boston, MA, on November 4, 2013, entitled “Organizational Values in Provision of Access to Care for the Uninsured.”

Funding

Dr. Harrison was supported by the AHRQ NRSA Health Services Research and Policy Traineeship (T32) and the Victor P. Raymond Memorial Fund Health Policy and Management Endowment Award when conducting this work, and is currently supported by the National Institute of Aging, T32-AG000212.

References

Ahn J, Kim G, Suh HS, Lee SM. Social values and health-care priority setting in Korea. Journal of Health Organization and Management. 2012; 26(3):343–50. [PubMed: 22852456]

Biron L, Rumbold B, Faden R. Social value judgments in healthcare: A philosophical critique. Journal of Health Organization and Management. 2012; 26(3):317–30. [PubMed: 22852454]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Blewett LA, Ziegenfuss J, Davern ME. Local access to care programs (LACPS): New developments in the access to care for the uninsured. Milbank Quarterly. 2008; 86(3):459–79. [PubMed: 18798886]

Clark S, Weale A. Social values in health priority setting: A conceptual framework. Journal of Health Organization and Management. 2012; 26(3):293–316. [PubMed: 22852453]

Creswell, JW. Qualitative inquiry and research design: Choosing among five approaches. 2. Thousand Oaks, CA: Sage; 2006.

Danis, M., Clancy, C., Churchill, LR. Ethical dimensions of health policy. New York, NY: Oxford University Press; 2005.

Docherty M, Cao Q, Wang H. Social values and health priority setting in China. Journal of Health Organization and Management. 2012; 26(3):351–62. [PubMed: 22852457]

Graber DR, Kilpatrick AO. Establishing values-based leadership and value systems in healthcare organizations. Journal of Health and Human Services Administration. 2008; 31(2):179–97. [PubMed: 18998522]

Joint Commission for Accreditation of Health Care Organizations. Comprehensive accreditation manual for hospitals: The official handbook. Oakbrook Terrace, IL: Joint Commission; 1995.

Keren R, Littlejohns P. Consideration of social values in the establishment of accountable care organizations in the USA. Journal of Health Organization and Management. 2012; 26(3):384–89. [PubMed: 22852460]

Kieslich K. Social values and health priority setting in Germany. Journal of Health Organization and Management. 2012; 26(3):374–83. [PubMed: 22852459]

Lewin ME, Baxter RJ. America's health care safety net: Revisiting the 2000 IOM Report. Health Affairs (Project Hope). 2007; 26(5):1490–94. [PubMed: 17848461]

Lewin, M., and Institute of Medicine (U.S.). America's health care safety net intact but endangered. Washington, DC: Institute of Medicine; National Academy Press; 2000.

Littlejohns P, Sharma T, Jeong K. Social values and health priority setting in England: 'Values' based decision making. Journal of Health Organization and Management. 2012; 26(3):363–73. [PubMed: 22852458]

Littlejohns P, Weale A, Chalkidou K, Faden R, Teerawattananon Y. Social values and health policy: A new international research programme. Journal of Health Organization and Management. 2012; 26(3):285–92. [PubMed: 22852452]

Marshall, C., Rossman, GB. Designing qualitative research. 4. Thousand Oaks, CA: Sage; 2006.

Maxwell, JA. Qualitative research design: An interactive approach. 2. Thousand Oaks, CA: Sage; 2004.

Miles, MB., Huberman, AM. Qualitative data analysis: An expanded sourcebook. 2. Thousand Oaks, CA: Sage; 1994.

Mills AE, Spencer EM. Values based decision making: A tool for achieving the goals of healthcare. HEC Forum. 2005; 17(1):18–32. [PubMed: 15957266]

Minyard, K., Chollet, D., Felland, L., et al. Lessons from local access initiatives: Contributions and challenges—The Commonwealth Fund. Washington, DC: Commonweath Fund; 2007. p. 66Available at: http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Aug/Lessons-from-Local-Access-Initiatives-Contributions-and-Challenges.aspx [October 26, 2010]

Nakashian, M. Communities in charge: Financing and delivering health care to the uninsured—Grant results reports. Robert Wood Johnson Foundation; 2007. Available at: http://www.rwjf.org/en/library/research/2007/04/communities-in-charge.html [October 27, 2010]

Nelson WA, Taylor E, Walsh T. Building an ethical organizational culture. Health Care Manager. 2014; 33(2):158–64. [PubMed: 24776835]

Ozar, D., Berg, J., Werhane, PH., Emanuel, LL. Organizational ethics in healthcare: Toward a model for ethical decision-making by provider organizations. Institute for Ethics National Working Group Report. Chicago, IL: Institute for Ethics, American Medical Association; 2000.

QSR International Pty Ltd. NVivo qualitative data analysis software (version 9). 2010. http://www.qsrinternational.com/products_previous-products_nvivo9.aspx

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Scotten E, Shirin L, Absher AC. Creating community-based access to primary healthcare for the uninsured through strategic alliances and restructuring local health department programs. Journal of Public Health Management and Practice. 2006; 12(5):446–51. [PubMed: 16912606]

Silow-Carroll, S., Alteras, T., Sacks, H. [October 26, 2010] Community-based health coverage programs: Models and lessons. Community Voices: Healthcare for the Underserved. 2004. Available at: http://www.communityvoices.org/PolicyBriefs.aspx

Tantivess S, Velasco RP, Yothasamut J, Mohara A, Limprayoonyong H, Teerawattananon Y. Efficiency or equity: Value judgments in coverage decisions in Thailand. Journal of Health Organization and Management. 2012; 26(3):331–42. [PubMed: 22852455]

Taylor EF, Cunningham P, McKenzie K. Community approaches to providing care for the uninsured. Health Affairs. 2006; 25(3):w173–82. [PubMed: 16608863]

Taylor EF, McLaughlin CG, Warren AW, Song PH. Who enrolls in community-based programs for the uninsured, and why do they stay? Health Affairs (Project Hope). 2006; 25(3):w183–91. [PubMed: 16608865]

Villegas, A. [February 8, 2010] Community health centers strained by recession, face bigger caseloads under reform. Kaiser Health News. 2009 Aug 7. Available at: http://www.kaiserhealthnews.org/Stories/2009/August/07/Community-health-centers.aspx

Weller, SC., Kimball Romney, A. Systematic data collection. Thousand Oaks, CA: Sage; 1988.

Winkler EC, Gruen RL. First principles: Substantive ethics for healthcare organizations. Journal of Healthcare Management/American College of Healthcare Executives. 2005; 50(2):109–19. discussion 119–20. [PubMed: 15839325]

Wynia MK. Personal responsibility, public policy, and the economic stimulus plan. Hastings Center Report. 2009; 39(2):13–15.

Yin, RK. Case study research: Design and methods. 4. Thousand Oaks, CA: Sage; 2008.

Author Manuscript

Table 1

Context and characteristics of participating community access programs (CAPs).

(As of 2011)	Site 1	Site 2
State context*		
Geographic region	Mid-Atlantic	Southeast
Persons per square mile, 2010	1,150	1,205
County population in 2011	293,142	1,267,775
Median household income, 2007–2011	$105,692	$50,195
Cost of living for one adult, 2011+	$23,373	$20,037
Population below poverty level, 2007–2011	4.5%	15.0%
Race/ethnicity		
White non-Hispanic	58.5%	53.0%
Black	18.2%	17.6%
American Indian/Alaska Native	0.4%	0.5%
Asian	14.9%	3.6%
Hispanic or Latino origin	6.0%	25.1%
Foreign-born persons, 2007–2011	17.6%	15.2%
Language other than English spoken at home, 2007–2011	21.9%	25.9%
CAP characteristics		
Blewett and colleagues typology	Local provider	County-based indigent care
Maturity (by founding date)	Young (>5 years)	Mature (20+ years)
Founding date	2008	1990
Founding context	National health reform effort; state all-payer system	State legal requirement for counties to cover indigent health care
Founding motivation	To create a model public health community; belief in right to access to care	Responding to the need to control health care costs for indigent over time
Administration of CAP	Nonprofit corporation staff members	County health and social service division employees
Oversight	Board of Trustees responsible for managing the business and affairs of the CAP.	Board of County Commissioners (BOCC) responsible for CAP policy for using county taxes to pay for indigent care. Advisory Board responsible for policy recommendations to BOCC for fund allocation, coordination, planning, and monitoring of health care delivery systems.
Funding	1/3 county monies; /3 monthly premiums from participants; 1/3 grants	Dedicated ½ cent county sales tax General county taxes
Annual budget	~$1,740,000 (including donated care)	~$132,762,000
Organization of services	One federally qualified health center medical home One hospital Ad hoc specialists Health coaches	4 healthcare networks (consisting of primary care physicians, specialists, and hospitals) responsible for acting as medical homes and providing managed care
Eligibility	County residents	County residents

(As of 2011)	Site 1	Site 2
	U.S. citizens and legal residents No source of insurance Up to 300% federal poverty level	U.S. citizens No source of insurance Under 100% federal poverty level Fewer than three felony convictions
Grounds for disenrollment	Nonpayment of premiums Nonparticipation in health coaching	After self-sufficiency model implemented, 2-year limit on services or lack of progress towards self-sufficiency
Membership	~750 at any one time	~14,000–17,000 at any one time

Note. Sources:

[*] quickfacts.census.gov;

[+] livingwage.mit.edu.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 2

Data collection and analysis.

Data type	Purpose	What or who	Analysis
Documents	Used as sources of description of CAP characteristics and context, key stakeholders, statements of organizational values, descriptions of resource allocation problems or outcomes. Also used to refine interview framework.	Websites, evaluations, materials for members or providers, annual reports, board meeting minutes, subcommittee meeting minutes, internal policies, presentations, newsletters, and/or bylaws	• Reviewed as collected to inform observations or interviews • Documents reviewed for relevance, converted to electronic format, and uploaded to NVivo for coding
Observations	Used to identify key decision makers and power dynamics, record statements of organizational values or goals as they occur organically in meetings, observe resource allocation decisions in process, and observe stakeholder agreements and disagreements about values or decisions. Also used to refine interview framework.	Board, manager, and staff meetings	• When permission given by participants, meeting recorded and transcribed; otherwise, hand-written notes of meeting process taken • Field notes taken of interpersonal dynamics • Field notes and transcripts uploaded to NVivo for coding
Interview 1	Used to elicit participants' descriptions of his/her role at the CAP, the population served by the CAP, how enrollees gain access to different categories of health services through the CAP, and tough issues or concerns encountered. Participants were also asked to describe one or two times when a decision was made about changing a health care service offered to enrollees.	CAP staff, managers, board members, and other stakeholders	• Audio-recorded, transcribed, and uploaded to NVivo for coding • Description of example resource allocation decision(s) was used to develop a visual diagram before interview 2
Interview 1: listing exercise	Used to identify stakeholder's perceptions of the values, goals, and commitments of the CAP and its stakeholder groups, including board members, population served, county health department, partner organizations, funders, and politicians.	Interview 1 participant	• Words or phrases mentioned more than once (by one participant or multiple participants) were written onto an index card for ranking exercise in interview 2. • All first interviews were completed and value cards completed before second interviews were conducted. • As part of interview 1, conversation recorded, transcribed, and uploaded to NVivo for coding
Diagram	Used to visualize process and outcomes of example resource allocation decision(s) described in interview 1.	Researcher (KLH)	• Iterative diagrams built of each incorporating new evidence and analysis
Interview 2: ranking exercise	Used to identify participant's perception of the relative importance of organizational values in decision-making. Participants were asked to review the index cards, then select 5–12 cards with the words or phrases that they believed were most important to the organization's resource allocation decisions that affected services offered to the uninsured. Participants were asked to rank order the selected cards according to	Interview 1 participant	• As part of interview 2, conversation recorded, transcribed, and uploaded to NVivo for coding

Data type	Purpose	What or who	Analysis
	the degree to which those factors affected resource allocation decisions in the CAP. Participants were also asked to discuss how the relative importance of values in such decisions has changed over time.		
Interview 2: diagram	Used to refine the description and diagram of the example resource allocation decision(s) discussed in interview 1. After engaging in the card sort exercise, participant asked to review the diagram of the process of the example resource allocation decision and clarify or add detail; next, the participant was asked to discuss how organizational values relate to the diagrammed decision.	Interview 1 participant	• Diagram revised to incorporated feedback of participant • As part of interview 2, conversation recorded, transcribed, and uploaded to NVivo for coding
Interview 2	Used to further explore the participants' perception of how organizational values influence resource allocation decisions. After completing the card sort and discussion of the diagram, the participant was asked to describe a resource allocation or policy decision that exemplified or stuck closely to the values of the CAP, to discuss factors that kept the decision in line with values, to discuss where the budget gets cut when solvency becomes and issue, and finally to discuss how organizational values play into the discussion of what to change.	Interview 1 participant	• Conversation recorded, transcribed, and uploaded to NVivo for coding

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 3

Data collected from two participating community access programs (CAPs).

	Site 1 (September 1–15, 2011)	Site 2 (November 3–19, 2011)
Documents	81 (of 868)	87 (of 190)
Observations	6	4
Interviews	15 with 9 people	26 with 19 people
-CAP staff	5	6
-Board members	2	6[*]
-Other stakeholders	2[+]	7[‡]

[*] One board member was a clinical provider and network head.

[+] As a result of chain referrals, stakeholders consisted of two founders.

[‡] As a result of chain referrals, stakeholders included one community member, two founders/former CAP executive directors, one former board member, and three other county health department staff members.